

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN2101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/17/2013
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, SMITHVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 825 FISHER AVE P O BOX 549 SMITHVILLE, TN 37166		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During the annual Licensure survey and investigation of complaint #31164, conducted on July 15-17, 2013, at NHC Healthcare Smithville, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *M. Clark* TITLE Administrator (X6) DATE 8/7/13

STATE FORM

6899

M5DB11

If continuation sheet 1 of 1

AUG 08 2013